STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155383	A. BUILDING 00 B. WING	08/23/2012

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F0000	This visit was for Investigation of Complaint IN00114290. Complaint IN00114290 - Substantiated, no deficiencies related to the allegations are cited. Unrelated deficiencies cited. Survey dates: August 22 & 23, 2012 Facility number: 000393 Provider number: 155383 AIM number: 100289340 Survey team: Mary Jane G. Fischer, RN Census bed type: SNF/NF: 82 Total: 82 Census payor type: Medicare: 10 Medicaid: 57 Other: 15 Total: 82 Sample: 4 These deficiencies reflect state findings	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	cited in accordance with 410 IAC 16.2. Quality review completed on August 27, 2012 by Bev Faulkner, RN			

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F0223 SS=D	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on observation, interview and record review, the facility failed to ensure a resident was free from physical abuse, in that when a resident required assistance with activities of daily living, the nursing staff member [Certified Nurses Aide employee #16] transferred the resident with rough care which resulted in bruising for 1 of 1 residents reviewed for abuse in a sample of 4. [Resident "D"] Findings include: The record for Resident "D" was reviewed on 08-23-12 at 9:34 a.m. Diagnoses included but were not limited to pneumonia, hypertension, acute hepatic encephalopathy, cirrhosis and	F0223	F223 - Abuse - **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident was observed for psychosocial well-being. Social service director conducted behavior/psychosocial assessment and interviewed other residents under care of CNA. No residents or staff has made any reports related to mistreatment by this employee or any other employees. Employee is no longer an employee at the facility. Resident interviews resulted in no further findings. Resident #1 has stated that she is not fearful of any aides in the building. - **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents have to potential to be	09/22/2012

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	depression. These diagnoses remained current at the time of the record review. During the initial tour of the facility on 08-22-12 at 11:00 a.m., the Unit Manager Licensed Practical Nurse employee #2 indicated the facility was currently investigating an allegation of abuse which involved a CNA [Certified Nurses Aide] and Resident "D". During an interview on 08-22-12 at 2:00 p.m., the Unit Manager indicated the CNA [in reference to employee #16] had been "written up on Monday [08-20-12]" for lack of care and using a cellular phone while on the unit. "It was a final warning with her. After I gave her the warning, I had her take a break, and then she went back to the Unit to work the evening shift. The next day [08-21-12] I found out [resident] had bruises and was stating that [name of employee #16] caused them. I went to talk to [resident] and said [name of the		affected. Residents have been questioned utilizing the abuse questionnaire. No identified concerns. Skin assessments completed on residents with no further findings. Staff in-service for: abuse, reporting abuse, Elder Justice Act, correct transfers, resident rights, customer service. - **what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Staff in-service for: abuse, reporting abuse, Elder Justice Act, correct transfers, resident rights, customer service, and recognizing staff burnout. Supervisors will observe for any staff members nearing burnout to provide reassurance. Some forms of reassurance may be: discussing with staff member any issues or concerns in order to mitigate the situation, review staffing patters, reassign residents if necessary, provide customer care training, discuss adopting healthy lifestyle choices (healthy eating, exercising, and sleeping habits), etc. In-services will be provided by 9/22/12. The following department heads will provide: · Staff Development Coordinator: Abuse, Reporting Abuse, Staff burnout · Therapy Department: Correct	

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	CNA] was upset about something and seemed mad. The resident said the CNA grabbed under [resident] arms to transfer. [Name of resident] demonstrated how the CNA reached out and grabbed [resident] upper arms. I don't know why [name of CNA] was transferring [resident] because [resident] likes the wheelchair next to the bed and can usually do it." When interviewed if the CNA [employee #16] used a gait belt the Unit Manager indicated, "No, [resident] doesn't like one to be used, even though we encourage it. She in reference to [CNA employee #16] was not scheduled to work today, but will be suspended pending investigation." Interview on 08-23-12 at 9:40 a.m., CNA employee #13 indicated, "I came in to work on Monday [08-20-12] around 6:00 a.m., and saw [resident's] call light was on. I put my things down and went down to answer the light. The night shift CNA put [resident] on the toilet		Transfers · Director of Marketing and Admissions: Customer Service and resident rights · Administrator: Elder Justice Act Supervisors and staff will monitor staff behavior to observe for staff burnout. If burnout is observed, appropriate action will be taken. Examples of appropriate action may include, but are not limited to: reassigning duties of staff, providing a break, sending staff home, discussing issues with a supervisor or an appointed guide in the facility, providing support and/or resources to reduce stress or offer guidance, etc. - **how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** An abuse CQI tool will be utilized weekly x 4, monthly x 2 and quarterly thereafter until 100% is achieved. The CQI Committee will review the data. If threshold of 100% is not achieved, an action plan will be developed. Re-education and or disciplinary action may occur for noncompliance. The CQI Committee will review the data for any unusual occurrences to ensure ISDH	

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	and needed help to get back to bed. I did, I helped [resident] back to bed and that's when [resident] told me that someone squeezed [resident] arms. I saw the bruises. [Name of resident] said 'when I have to go to the bathroom, I have to go. She [in reference to CNA #16] seemed mad about something but I don't know what she was mad about.' Someone in therapy saw the back of [resident] arm on Monday but at the time [resident] didn't know how the bruises happened. [Resident] told me that when [name of CNA #16] transferred [resident] again later that day [realized] that's the same way it felt when [name of CNA #16] transferred [resident] earlier that day." Interview on 08-23-12 at 10:00 a.m., CNA employee #12 indicated, "She [in reference to CNA employee #16] seemed aggravated - yes even early in the day [in reference to Monday 08-20-12]. You could obviously see she was aggravated about something. She		guidelines were appropriately followed. Administrator will continue to fully investigate all unusual occurrences and will follow ISDH guidelines for reporting unusual occurrences. - **by what date the systemic changes will be completed.** The systematic changes will be completed by September 22, 2012	

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	had something on her mind." Interview on 08-23-12 at 10:30 a.m., the Occupational Therapist Assistant employee #15 indicated, "I treated [name of resident] later in the afternoon on Monday, 08-20-12, and [resident] had bruises on the left arm. [Resident] does have some skin discoloration issues, but this was a bruise and it seemed light in color. [Resident] wasn't sure how the bruises happened. When I came into work on Tuesday, I heard there was an investigation about the bruises." Review of witness statements as follows: 08-21-12 Licensed Practical Nurse employee #14 "As I went in to [name of resident] to give a.m. med's [name of resident] showed me a bruise on each arm and stated, '[Name of CNA employee #16] squeezed my arms and was rough with me while helping me off the toilet. I immediately told [sic] Unit			

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	Manager." 08-21-12 Unit Manager Licensed Practical Nurse employee #2 "I was approached by [name of Licensed Practical Nurse employee #14] stating that [resident] was upset and had bruises. When talking to [resident] stated that yesterday afternoon [name of CNA employee #16] answered the call light and asked to go to the bathroom and [name of CNA employee #16] told [resident] to just use the bedpan and [resident] replied, 'No I will just make a mess I want to go to the bathroom.' [Name of resident] felt that [CNA employee #16] was in a bad mood and taking it out on [resident] when she went to help [resident] into the chair. [CNA #16] 'squeezed arms really tight' pointing to bilat. [bilateral] upper posterior arms. Assessed areas and observed bruises to bilat. upper arms. Assured resident that the issue would be addressed and asked if [resident] felt scared and [resident]			

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	said no and did not want to get anyone into trouble but she [in reference to CNA #16] really hurt [resident] and did not understand why she [CNA #16] took out her anger on [resident]." Interview on 08-22-12 at 11:30 a.m., the Director of Nurses indicated she as well as the Administrator had been informed of the alleged abuse by the Unit Manager Licensed Practical Nurse employee #2, and the State Agency had already been informed. Interview on 08-23-12 at 9:00 a.m., the Administrator verified CNA employee #16 had been suspended. Interview on 08-23-12 at 11:20 a.m., Resident "D" indicated the following: "I knew something was wrong - she was mad when she came to work on Monday [08-20-12]. I knew she had problems with her ankle but that wasn't it. She was mad [emphatic]. That was the start of			

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	the day. I have to use the bathroom a lot because of the Lactulose [an osmotic laxative] I take, and when I have to go I have to go. She did help me get in the wheelchair earlier in the day, before lunch and I thought it was a little rough but she took me to the bathroom. I had to use the bathroom several times that day, and when I used my call light to let her know I had to go again, she came into my room and said, 'If you can't help yourself, you're just going to have to use a bedpan.' I knew there would be a bigger mess if a bedpan was used and she would really be mad. She didn't use a belt [transfer aid] because of my abdomen, it really hurts. I'm on the transplant list for a new liver, and so I have to be careful. I got to the side of the bed and she grabbed both of my arms, like this [resident positioned both arms in front of self towards surveyor upper arms], and in one movement she threw me into my wheelchair. Once she grabbed me like that it brought back how she			

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	transferred me earlier in the day and hurt my left arm. It startled me." Observation on 08-23-12 at 11:20 a.m., were bruises to the right inner arm and upper posterior arm. Both bruises were purple in color. The bruising to the left upper arm was light purple in color. Record review indicated "Non-pressure Wound Skin Evaluation," dated 08-21-12 at 8:54 a.m. indicated the following: "Right inner arm - new area, bruise. 1.0 cm. [centimeters] in length by 1.4 cm. in width - purple in color." "Right posterior upper arm - new area, bruise. #1. 2.5 cm. in length by 4.5 cm. in width - light purple in color." #2. 2.0 cm. in length by 2.0 cm. in width. "Left posterior upper arm - new area, bruise. 5.0 cm in length by 4.0 cm. in width - light purple in			

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	color." Review of the facility policy on 08-23-12 at 10:30 a.m., provided by the Administrator, titled "ABUSE PROHIBITION, REPORTING, AND INVESTIGATION [BOLD TYPE] - POLICY AND PROCEDURE," dated February 2012, indicated the following: "It is the policy of American Senior Communities to protect residents from abuse including physical abuse, sexual abuse, verbal abuse, mental abuse, neglect, involuntary seclusion, and misappropriation of resident property and/or funds." "Physical abuse [underscored] - includes hitting, slapping, punching, and kicking. It also includes controlling behavior through corporal punishment." "POLICY/PROCEDURE [bold type]: 1. American Senior Communities will not permit residents to be subjected to abuse			

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	by anyone, including employees, other residents, consultants, volunteers,staff or personnel of other agencies serving the resident, family members, legal guardians, sponsors, friends or other individuals." 3.1-27(a)			